		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032011

Facility Name: Norridge Hlthcr & Rehab Centre

Address: 7001 W. cullom Ave. (Number) Norridge (City) 60656 (Zip Code)

County: Cook

Telephone Number: (708) 457-0700 **Fax #** (708) 457-8852

IDPA ID Number: 36-3485852

Date of Initial License for Current Owners: 1-Jan-1987

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-03 to 31-Dec-03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 31-March-2004 (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	210	Skilled (SNF)	210	76,650	1
2		Skilled Pediatric (SNF/PED)			2
3	105	Intermediate (ICF)	105	38,325	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	315	TOTALS	315	114,975	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	50,000	19,042	12,640	81,682	8
9	SNF/PED					9
10	ICF	12,625	1,820		14,445	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,625	20,862	12,640	96,127	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.61%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1-Jan-1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1-Jan-1987 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 210 and days of care provided 11,811

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	549,459	78,317	25,530	653,306		653,306		653,306			1
2	Food Purchase		591,184		591,184	(24,411)	566,773	(1,157)	565,616			2
3	Housekeeping	361,875	71,317		433,192		433,192		433,192			3
4	Laundry	180,120	80,723		260,843		260,843		260,843			4
5	Heat and Other Utilities			283,387	283,387		283,387		283,387			5
6	Maintenance	94,149	155,773	108,524	358,446		358,446	7,363	365,809			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,185,603	977,314	417,441	2,580,358	(24,411)	2,555,947	6,206	2,562,153			8
	B. Health Care and Programs											
9	Medical Director			34,000	34,000		34,000		34,000			9
10	Nursing and Medical Records	4,344,172	296,367	45,359	4,685,898		4,685,898		4,685,898			10
10a	Therapy		467	8,327	8,794		8,794		8,794			10a
11	Activities	150,685	27,826	2,063	180,574		180,574		180,574			11
12	Social Services	153,406		3,861	157,267		157,267		157,267			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Dental Services			45	45		45		45			15
16	**TOTAL Health Care and Programs**	4,648,263	324,660	93,655	5,066,578		5,066,578		5,066,578			16
	C. General Administration											
17	Administrative	116,377		463,050	579,427		579,427	(232,622)	346,805			17
18	Directors Fees											18
19	Professional Services			39,844	39,844		39,844	32,347	72,191			19
20	Dues, Fees, Subscriptions & Promotions			45,549	45,549		45,549	21,334	66,883			20
21	Clerical & General Office Expenses	318,909	51,491	57,617	428,017		428,017	172,540	600,557			21
22	Employee Benefits & Payroll Taxes			1,017,009	1,017,009	24,411	1,041,420	131,907	1,173,327			22
23	Inservice Training & Education			1,195	1,195		1,195		1,195			23
24	Travel and Seminar			14,271	14,271		14,271	17,089	31,360			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,550	38,550		38,550		38,550			26
27	Other (specify):*							23,812	23,812			27
28	**TOTAL General Administration**	435,286	51,491	1,677,085	2,163,862	24,411	2,188,273	166,407	2,354,680			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,269,152	1,353,465	2,188,181	9,810,798		9,810,798	172,613	9,983,411			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre #0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			251,318	251,318		251,318	434,796	686,114			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			836	836		836	1,510,337	1,511,173			32
33	Real Estate Taxes			433,817	433,817		433,817		433,817			33
34	Rent-Facility & Grounds			2,484,119	2,484,119		2,484,119	(2,484,000)	119			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,170,090	3,170,090		3,170,090	(538,867)	2,631,223			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		254,419	480,795	735,214		735,214		735,214			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,463	172,463		172,463		172,463			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		254,419	653,258	907,677		907,677		907,677			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,269,152	1,607,884	6,011,529	13,888,565		13,888,565	(366,254)	13,522,311			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(93,880)	30		9
10	Interest and Other Investment Income	(72)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,157)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(860)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,200)	21		24
25	Fund Raising, Advertising and Promotional	(35,323)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,500)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,441)	20		28
29	Other-Attach Schedule (Per page 5A attached)	427	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (143,006)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(223,248)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (223,248)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (366,254)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Norridge Hlthcr & Rehab Centre

ID# 0032011

Report Period Beginning: 1-Jan-03

Ending: 31-Dec-03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenace Expense (Page 22)	$ 427	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	427		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,157)	0	0	0	0	0	0	0	0	0	0	(1,157)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	427	6,936	0	0	0	0	0	0	0	0	0	7,363	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(730)	6,936	0	0	0	0	0	0	0	0	0	6,206	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(232,622)	0	0	0	0	0	0	0	0	0	(232,622)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	32,347	0	0	0	0	0	0	0	0	0	32,347	19
20	Fees, Subscriptions & Promotions	(37,624)	58,958	0	0	0	0	0	0	0	0	0	21,334	20
21	Clerical & General Office Expenses	(10,700)	180,740	2,500	0	0	0	0	0	0	0	0	172,540	21
22	Employee Benefits & Payroll Taxes	0	131,907	0	0	0	0	0	0	0	0	0	131,907	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	17,089	0	0	0	0	0	0	0	0	0	17,089	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	23,812	0	0	0	0	0	0	0	0	0	23,812	27
28	**TOTAL General Administration**	(48,324)	212,231	2,500	0	0	0	0	0	0	0	0	166,407	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(49,054)	219,167	2,500	0	0	0	0	0	0	0	0	172,613	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Norridge Hlthcr & Rehab Centre **#** 0032011 **Report Period Beginning:** 1-Jan-03 **Ending:** 31-Dec-03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(93,880)	1,844	526,832	0	0	0	0	0	0	0	0	434,796	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(72)	25,077	1,485,332	0	0	0	0	0	0	0	0	1,510,337	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(2,484,000)	0	0	0	0	0	0	0	0	(2,484,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(93,952)	26,921	(471,836)	0	0	0	0	0	0	0	0	(538,867)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(143,006)	246,088	(469,336)	0	0	0	0	0	0	0	0	(366,254)	45

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Officers' Salaries	$	Lancaster, Ltd.	100.00%	$ 221,343	$ 221,343	1
2	V	27	Payroll Taxes-Officers		Lancaster, Ltd.	100.00%	8,892	8,892	2
3	V	17	Management Fee Income	463,050	Lancaster, Ltd.	100.00%		(463,050)	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	32,347	32,347	4
5	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	180,740	180,740	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	131,907	131,907	6
7	V	24	Education and Seminars		Lancaster, Ltd.	100.00%	17,089	17,089	7
8	V	17	Administrative Consultant		Lancaster, Ltd.	100.00%	9,085	9,085	8
9	V	20	Fees and Marketing		Lancaster, Ltd.	100.00%	58,958	58,958	9
10	V	32	Interest	836	Lancaster, Ltd.	100.00%	25,913	25,077	10
11	V	30	Depreciation		Lancaster, Ltd.	100.00%	1,844	1,844	11
12	V	6	Maintenance		Lancaster, Ltd.	100.00%	6,936	6,936	12
13	V	27	Payroll Taxes-Clerical		Lancaster, Ltd.	100.00%	14,920	14,920	13
14	Total			$ 463,886			$ 709,974	$ * 246,088	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental	$ 2,484,000	Norridge Associates	100.00%	$	$ (2,484,000)	15
16	V	30	Depreciation		Norridge Associates	100.00%	526,832	526,832	16
17	V	32	Interest	14,668	Norridge Associates	100.00%	1,500,000	1,485,332	17
18	V	21	IL State Replacement Tax		Norridge Associates	100.00%	2,500	2,500	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,498,668			$ 2,029,332	$ * (469,336)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Laurence Zung	Executive Officer	Administrative	40.00%	See Attached	24	50.00	Lancaster	$ 170,652	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	6.00%	See Attached	9	19.00	Lancaster	27,757	17-7	2
3	Cheryl Morris	VP-Operations	Administrative	6.00%	See Attached	9	19.00	Lancaster	22,934	17-7	3
4	Sandra Bernett	Administrator	Administrator	5.00%	See Attached	40	100.00	Lancaster	0	17-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 221,343		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: (773) 478-3699
Fax Number: (773) 478-1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Laurence Zung	Hours Worked	48	7	$ 341,304	$ 341,304	24	$ 170,652	1
2	27	Laurence Zung	Hours Worked	48	7	11,443	0	24	5,722	2
3	17	Christopher Vicere	Hours Worked	48	7	148,036	148,036	9	27,757	3
4	27	Christopher Vicere	Hours Worked	48	7	8,641	0	9	1,620	4
5	17	Cheryl Morris	Hours Worked	48	7	122,314	122,314	9	22,934	5
6	27	Cheryl Morris	Hours Worked	48	7	8,268	0	9	1,550	6
7										7
8										8
9	19	Professional Services	Management Fees	1,974,210	7	137,913	0	463,050	32,347	9
10	21	Clerical Expenses	Management Fees	1,974,210	7	58,516	0	463,050	13,725	10
11	22	Employee Benefits	Management Fees	1,974,210	7	562,384	0	463,050	131,907	11
12	24	Education and Seminars	Management Fees	1,974,210	7	23,865	0	463,050	5,598	12
13	17	Administrative Consultant	Management Fees	1,974,210	7	38,732	38,732	463,050	9,085	13
14	20	Marketing	Management Fees	1,974,210	7	245,986	171,548	463,050	57,696	14
15	32	Interest	Management Fees	1,974,210	7	47,944	0	463,050	11,245	15
16	30	Depreciation	Management Fees	1,974,210	7	7,864	0	463,050	1,844	16
17	20	Licenses and Fees	Management Fees	1,974,210	7	5,379	0	463,050	1,262	17
18	6	Maintenance	Management Fees	1,974,210	7	29,570	0	463,050	6,936	18
19	24	Travel	Management Fees	1,974,210	7	48,990	0	463,050	11,491	19
20	21	Salaries-Clerical	Management Fees	1,974,210	7	712,068	712,068	463,050	167,015	20
21	27	Payroll Taxes-Clerical	Management Fees	1,974,210	7	63,611	0	463,050	14,920	21
22										22
23	32	Direct Interest							13,832	23
24										24
25	TOTALS					$ 2,622,828	$ 1,534,002		$ 709,138	25

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Interest Income			Received from IDPH			$	$			$	1
2				under Illinois Prompt Payment Act								2
3												3
4												4
5												5
	Working Capital											
6	BankOne		X	Working Capital							11,245	6
7	Harston Investments		X								1,500,000	7
8			X									8
9	TOTAL Facility Related						$	$			$ 1,511,245	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 1,511,245	15
											($72) @	
											$1,511,173	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

@ Received from IDPH under Illinois Prompt Payment Act

Facility Name & ID Number Norridge Hlthcr & Rehab Centre **#** 0032011 **Report Period Beginning:** 1-Jan-03 **Ending:** 31-Dec-03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	445,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	438,817	2
3. Under or (over) accrual (line 2 minus line 1).	$	(6,183)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	440,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	433,817	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	441,463	8
	1999	446,465	9
	2000	447,232	10
	2001	437,929	11
	2002	438,817	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Norridge Hlthcr & Rehab Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032011

CONTACT PERSON REGARDING THIS REPORT Christopher vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-18-318-005-0000	Long-Term Healthcare	$ 109,546.72	$ 109,546.72
2.	13-18-318-006-0000	Long-Term Healthcare	$ 109,546.72	$ 109,546.72
3.	13-18-318-007-0000	Long-Term Healthcare	$ 110,176.59	$ 110,176.59
4.	13-18-318-008-0000	Long-Term Healthcare	$ 109,546.72	$ 109,546.72
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 438,816.75	$ 438,816.75

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,972 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Care Facility		1986	$ 650,000	1
2	Sec. 754 basis adjustment			126,788	2
3	TOTALS			$ 776,788	3

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1986	1976	$ 9,204,000	$ 478,608	30	$ 478,608	$	$ 6,255,652	4
5					1,315,965	41,777	30	41,777		486,937	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	43,548	1,382	20	2,177	795	35,038	9
10	Various			1988	3,940	125	20	197	72	3,589	10
11	Various			1988	28,574	1,015	20	1,190	175	27,797	11
12	Various			1989	1,297	41	20	65	24	1,021	12
13	Various			1990	3,827	121	20	191	70	2,895	13
14	Various			1990	28,644	909	20	1,433	524	18,907	14
15	Various			1991	72,916	2,314	20	3,650	1,336	44,543	15
16	Various			1992	36,639	1,352	20	1,944	592	21,343	16
17	Various			1993	72,513	1,920	20	3,627	1,707	36,827	17
18	Various			1994	116,353	3,068	20	5,854	2,786	52,265	18
19	Various			1995	95,409	2,447	20	4,770	2,323	40,317	19
20	Boiler/Hot Water Heater Improvements			1996	9,417	241	20	471	230	3,537	20
21	Tuckkpointing			1999	28,900	741	20	1,445	704	6,963	21
22	Architect Fee 1st Floor			2001	15,052	386	20	386		1,110	22
23	Construction 1st Floor			2001	166,662	4,273	20	4,273		12,286	23
24	Construction Library			2001	12,461	320	20	320		919	24
25	Design Fee-1st Floor			2001	5,130	132	20	132		379	25
26	Sprinklers-1st Floor			2001	4,531	116	20	116		334	26
27	Demolition-1st Floor			2001	5,533	142	20	142		408	27
28	Wooden Doors (2)			2001	1,134	29	20	29		84	28
29	Construction Work			2002	4,207	108	20	108		247	29
30	Smoking Shelter			2002	3,251	83	20	325	242	650	30
31	Auto Front Door			2002	2,074	53	20	207	154	328	31
32	Fence In Lot			2003	2,972	1,560	20	50	(1,510)	50	32
33	Building new-Town Square			2003	281,539	4,298	20	3,251	(1,047)	3,251	33
34	Roofing			2003	62,440	200	20	1,041	841	1,041	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,628,928	$ 547,761		$ 557,779	$ 10,018	$ 7,058,718	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 722,211	$ 83,448	$ 96,347	$ 12,899	10	$ 935,261	71
72	Current Year Purchases	742,946	142,108	31,824	(110,284)	10	31,824	72
73	Fully Depreciated Assets	478,477	6,677	164	(6,513)		478,477	73
74								74
75	TOTALS	$ 1,943,634	$ 232,233	$ 128,335	$ (103,898)		$ 1,445,562	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,349,350	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 779,994	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 686,114	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (93,880)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,504,280	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ***N/A - Related Party Lease***

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 222,187	$		$ 222,187	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			27,589			27,589	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			231,019			231,019	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				223,943		223,943	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): MedSup/Sp Bed Rent	39-2					30,476		30,476	13
14	TOTAL			$		$ 480,795	$ 254,419		$ 735,214	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (39,864)	$ (33,220)	1
2	Cash-Patient Deposits	97,639	97,639	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,478,875	3,478,875	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,029	55,029	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	174,040	285,730	8
9	Other(specify): Employee Advances	37,145	37,145	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,802,864	$ 3,921,198	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		776,788	13
14	Buildings, at Historical Cost		10,519,965	14
15	Leasehold Improvements, at Historical Cost	764,983	1,108,962	15
16	Equipment, at Historical Cost	1,458,962	1,943,634	16
17	Accumulated Depreciation (book methods)	(1,402,821)	(10,622,163)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		165,278	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(165,278)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Goodwill	100,000	100,000	22
23	Other(specify): **Construction in Progress	1,155	1,155	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 922,279	$ 3,828,341	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,725,143	$ 7,749,539	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 211,402	$ 281,434	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	196,316	196,316	28
29	Short-Term Notes Payable		29,644	29
30	Accrued Salaries Payable	577,573	577,573	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,711	16,711	31
32	Accrued Real Estate Taxes(Sch.IX-B)	440,000	440,000	32
33	Accrued Interest Payable	51,502	51,502	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Employee 401(k) Contributions**	7,196	7,196	36
37	**Wage Assignments**	1,745	1,745	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,502,445	$ 1,602,121	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		15,000,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 15,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,502,445	$ 16,602,121	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,222,698	$ (8,852,582)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,725,143	$ 7,749,539	48

***(See instructions.)**

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,408,056	1
2	Restatements (describe):		2
3			3
4	***Adjustment of book depreciation for taxation***	(39,616)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,368,440	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	854,258	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,000,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (145,742)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,222,698	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ (7,903,227)	1
2	Restatements (describe):		2
3			3
4	***Adjustment of book depreciation for taxation***	(39,616)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (7,942,843)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,323,594	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,233,333)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (909,739)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (8,852,582)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,029,410	1
2	Discounts and Allowances for all Levels	(2,334,688)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,694,722	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,431,911	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,431,911	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	35,968	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	378,480	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,855	19
20	Radiology and X-Ray	27,710	20
21	Other Medical Services	125,105	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 610,118	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	72	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 72	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	6,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,742,823	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,580,358	31
32	Health Care	5,066,578	32
33	General Administration	2,163,862	33
	B. Capital Expense		
34	Ownership	3,170,090	34
	C. Ancillary Expense		
35	Special Cost Centers	735,214	35
36	Provider Participation Fee	172,463	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,888,565	40
41	**Income before Income Taxes (line 30 minus line 40)****	854,258	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 854,258	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.** ***Cash Basis TaxPayer***

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,957	2,286	$ 94,223	$ 41.22	1
2	Assistant Director of Nursing	1,861	2,140	76,075	35.55	2
3	Registered Nurses	44,365	46,080	1,250,791	27.14	3
4	Licensed Practical Nurses	31,483	33,986	805,870	23.71	4
5	Nurse Aides & Orderlies	161,254	173,768	1,745,081	10.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,989	2,248	44,675	19.87	9
10	Activity Assistants	10,562	11,586	106,010	9.15	10
11	Social Service Workers	10,366	11,635	153,406	13.18	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	52,335	56,203	549,459	9.78	15
16	Dishwashers					16
17	Maintenance Workers	5,963	6,491	94,149	14.50	17
18	Housekeepers	37,904	41,312	361,875	8.76	18
19	Laundry	20,896	22,750	180,120	7.92	19
20	Administrator	1,911	2,086	81,062	38.86	20
21	Assistant Administrator	1,695	1,725	35,315	20.47	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,626	22,348	318,909	14.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	20,116	21,583	372,132	17.24	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	425,283	458,227	$ 6,269,152 *	$ 13.68	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	851	$ 25,530	1-3	35
36	Medical Director	850	34,000	9-3	36
37	Medical Records Consultant	115	4,158	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	859	12,885	10-3	39
40	Physical Therapy Consultant	238	8,327	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	43	2,063	11-3	44
45	Social Service Consultant	102	3,861	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,058	$ 90,824		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	726	$ 28,316	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	726	$ 28,316		53

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Bernett	Administrator	N/A	$ 81,062
Safet Keljalic (January-October)	Asst.Administrator	N/A	35,315
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 116,377

B. Administrative - Other

Description	Amount
Management Fees-Lancaster, Ltd.	$ 463,050
TOTAL (agree to Schedule V, line 17, col. 3)	$ 463,050
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Stone, Pogrund & Korey	Legal	$ 9,277
Winston & Strawn	Legal	2,935
Personnel Planners, Inc.	Payroll Tax Consultant	2,250
Richard Peelo & Associates	Accounting	2,250
Frost, Ruttenberg & Rothblatt	Accounting	1,995
Computer MD, Inc.	Data Processing	3,356
Accu-Med Services, Inc	Data Processing	2,746
Health Data Systems, Inc.	Data Processing	10,595
Medi.Com	Data Processing	1,260
Advanced Telecommunication	Data Processing	813
Msci	Data Processing	2,368
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 39,844

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,858
Unemployment Compensation Insurance	53,456
FICA Taxes	467,798
Employee Health Insurance	332,673
Employee Meals	24,411
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	5,815
Retirement Plan Contributions	60,448
Misc. Employee Benefits	23,961
Lancaster Allocation	131,907
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,173,327

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 500
Advertising: Employee Recruitment	5,614
Health Care Worker Background Check	
(Indicate # of checks performed 78)	1,014
Promotional Advertising	36,764
Contributions	860
Dues & Subscriptions	550
Licenses & Fees	247
Related Parties Allocation	58,958
Less Contributions	(860)
Less: Public Relations Expense	( )
Non-allowable advertising	(35,323)
Yellow page advertising	(1,441)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 66,883

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	244
Seminar Expense	14,027
Lancaster Allocation	17,089
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 31,360

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Painting & Decorating	Jul-97	$ 3,238	3	$ 540	$	$	$	$	$	$	$	$
2	Painting & Decorating	Nov-97	2,814	3	469								
3	Painting & Decorating	Mar-98	4,660	3	1,553	777							
4	Painting & Decorating	May-98	3,318	3	1,106	553							
5	Painting & Decorating	Aug-99	2,834	3	945	945	472						
6	Painting & Decorating	Nov-99	1,966	3	655	655	328						
7	Painting & Decorating	Mar-2000	585	3	195	195	98						
8	Painting & Decorating	Oct-2000	266	3	88	88	45						
9	Painting & Decorating	Nov-2000	50	3	17	17	8						
10	Painting & Decorating	Dec-2000	180	3	60	60	30						
11	Painting & Decorating	Aug-2001	1,281	3		214	427	427	213				
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 21,192		$ 5,628	$ 3,504	$ 1,408	$ 427	$ 213	$	$	$	$

Facility Name & ID Number Norridge Hlthcr & Rehab Centre **#** 0032011 **Report Period Beginning:** 1-Jan-03 **Ending:** 31-Dec-03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,554** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **172,463**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **24,411** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.